BERRIEN MENTAL HEALTH AUTHORITY
-- PROCEDURE --

SUBJECT: REPORTING & REVIEW OF RECIPIENT DEATHS	SECTION: 01-06-02 Page 1 of 4
APPLICATION: All Staff; All Network Providers EFFECTIVE DATE: 7/01/91 APPROVED BY: _____ Chief Executive Officer REVISED: 10/94, 5/96, 9/99, 03/2002, 11/04, 11/05, 3/08, 9/11, 9/12, 7/13, 11/15, 6/16, 6/19, 4/20, 11/2020, 7/2022, 8/2023, 8/2024	REQUIRED BY: MDHHS Contract

POLICY:
It is the policy of the Berrien Mental Health Authority (BMHA) that all deaths of persons receiving services at the time of death be internally reported by the primary clinician and or contracted service provider and reviewed by the Office of Recipient Rights (ORR). BMHA will comply with the contractual requirement of the Michigan Department of Health and Human Services (MDHHS) regarding deaths of recipients, as well as, accrediting body required actions. Data and other related information may be used for quality improvement purposes. If further action including a Root Cause Analysis (RCA) is required, as a result of the initial ORR review, this will be facilitated so that the appropriate individuals also review the death and circumstances.

PURPOSE:
1. To define the roles, responsibilities, and mechanisms for uniform and timely reporting of deaths for consumers of mental health & substance use services.
2. To define the roles and responsibilities for review and investigation of deaths of consumers receiving mental health & substance use services, as well as utilizing data and other information to improve the quality of care of consumers.
3. To define what circumstances, location and/or level of services require additional timely notification to the Director of Regulatory Compliance for root cause analysis, critical incident analysis, accrediting body reporting, MDHHS reporting, Protective Services and/or Police.

STANDARD:
1. All deaths of recipients of mental health & substance use services shall be reported to the Recipient Rights Office within twenty-four (24) hours of the death or within twenty-four (24) hours of becoming aware of the recipient death via e-mail, telephone, or voice mail.
2. An electronic or written report of unusual incident (IR) form shall be completed ASAP, but no later than twenty-four (24) hours after knowledge of the death; or next business day worked and forwarded to the ORR through each team or service provider's chain of command.

3. A written Report of Death form shall be completed by the primary clinician or designee and forwarded to the Recipient Rights Office within four (4) business days of becoming aware of the death. *(Form is located on the Knowledge Network under Recipient Rights as well as in the internal policy & procedures manual).*
4. A certified copy of the certificate of death shall be obtained and provided to the ORR as soon as it is available from the County Clerk's Office in the County or State the individual died, from the Funeral Director, or the family, as soon as it is available. Forward the certificate to the ORR within (10) business days of becoming aware of the death or *as soon as it is available*. It is important to obtain this ASAP as cause of death is a determining factor in facilitating additional investigation, review and regional and state reporting.
5. Within two (2) business days after receiving notification of the consumer death, the Office of Recipient Rights will make a determination if it is a sentinel event, critical incident or risk event, (if the necessary information to make such a determination is available, i.e. death certificate determining cause of death). If it is determined a root cause analysis is needed, the Office of Recipient Rights will initiate a root cause analysis meeting within two (2) business days.

PROCEDURE:
ROLE OF THE PRIMARY CARE GIVER – Death at a Service Site

1. Call emergency medical personnel immediately and administer life saving interventions as appropriate;
2. Call Police and Protective Services if circumstances surrounding death are suspicious in any way;
3. Contact the next of kin and/or legal guardian if the person has one appointed;
4. Cooperate with providing ambulance personnel, police or hospital personnel with necessary information to assist in determining the cause of death and appropriate disposition of remains;
5. Report the incident to the designated supervisor or administrator of the facility/program immediately;
6. Report the incident to the Office of Recipient Rights and Primary Clinician via e-mail, telephone or voicemail ASAP;
7. Complete the written Report of Unusual Incident (IR) ASAP, but no later than (24) hours or next business day worked, and forward to the ORR through each team or service provider's determined process or chain of command;
8. Assist as able/needed in the funeral planning process;
9. The service provider or designated representative should in addition to those listed above assist in contacting the following individuals or agencies as appropriate:
    - Adult Foster Care Licensing Representative (if it is a licensed setting)
    - BMHA Primary Clinician
    - BMHA Treating Psychiatrist
    - BMHA Provider Network
    - BMHA Billing/Business Office
    - Employer
    - Social Security Administration
    - Department of Health & Human Services

- Any other program supervisor, agency, physician(s) with whom the person has obligations;

10. Actively participate as requested by the clinical incident or root cause/mortality analysis group, if conducted.

ROLE OF THE PRIMARY CLINICIAN

1. Report the incident to the Office of Recipient Rights via e-mail, telephone or voice-mail ASAP; within twenty-four (24) hours of the death or within twenty-four (24) hours of becoming aware of the recipient death.
2. Notify Supervisor;
3. Complete a Report of Unusual Incident (IR) ASAP, but no later than (24) hours of the time knowledge of the death occurs and forward to the Recipient Rights Office;
4. If in a residential setting assist the service provider with the notifications and reporting to the appropriate individuals identified above in #9 bullets as needed;
5. If in an independent setting or living with family, assist the natural supports with coping and reporting to the appropriate individuals identified above in #9 bullets as needed;
6. Complete a Report of Death and forward to ORR within (4) business days of becoming aware of the death. If more pertinent information becomes available after the initial report, the clinician will provide the ORR with a follow-up report;
7. Assist as requested in a review of the death or investigation if opened;
8. Actively participate in the Root Cause Analysis group if conducted.

ROLE OF THE SUPERVISOR OR TEAM COORDINATOR

1. Assure/assist the primary clinician in fulfilling their roles in the Death Reporting process;
2. Assure that the consumer's chart has been updated with their date of death.
3. Assist as requested in a review of the death or investigation if opened;
4. Actively participate in the Root Cause Analysis group if conducted.
5. If contracted service provider, also follow your agency policies in regard to resident/consumer deaths.

ROLE OF THE OFFICE OF RECIPIENT RIGHTS

1. Report suspicious recipient death notifications or those meeting mandatory reporting requirements (upon determination) immediately to the Chief Executive Officer, Director of Services & Medical Director;
2. Report deaths that are potential critical incidents or root cause analysis issues to the CQI Coordinator ASAP for reporting to PIHP and CARF and assist with reporting as necessary.
3. Initiate a review/overview of the circumstances around the death of the person within (48) business hours of the reported death;
4. Review written home and medical records, IR, Report of Death, death certificate, autopsy report, police report and any other pertinent information, to determine if any potential rights violation or other reportable circumstance was present and requires further action or a complaint to be opened;

5. The Rights Office will ensure that notifications are made to the BMHA Treating Psychiatrist, Provider Network and the Billing/Business Office.
6. The Rights Office will request the death certificate, autopsy reports and police reports as applicable.
7. Provide CQI Coordinator with ongoing information as it develops, as appropriate so that action can be taken;
8. Assure Utilization Management has been notified of the resident death;
9. Assist in obtaining Police reports or autopsy results if needed;
10. Provide overview of deaths reported in Rights Director Report to the Recipient Rights Advisory Committee at scheduled meetings;
11. Provide MDHHS reportable death and critical incident information to the Clinical Data Specialist and Regional entity designee as requested;
12. For deaths not investigated through a formal Rights process, the Rights Office will maintain a death report file that includes the original death certificate, clinical summary and any autopsy or police reports for individuals with covered services or residing in covered settings.

FORMS:
Report of Unusual Incident *(*Electronic form is in BMHA EMR IRIS and on the BMHA - Riverwood Website. Hard copy forms are also available.*)
Report of Death (01-06-02 FORM w/ data fields – precedes the procedure in the P & P Manual on the shared drive)

RELATED PROCEDURE:
010604 Critical Incident, Sentinel Event & Risk Event Reporting

Reviewer: Office of Recipient Rights
Reviewed: 4/07, 7/09, 6/10, 9/11, 5/12, 9/12, 7/13, 4/14, 7/15, 11/15, 6/16, 4/17, 7/18, 6/19, 4/2020, 11/2020, 4/2021, 7/2022, 8/2023, 8/2024, 8/2025